HEALTH QUESTIONNAIRE

STD. 610 HQ (REV. 5-96) (Page 1 of 2)

STATE LAW AND THE AMERICANS WITH DISABILITIES ACT REQUIRE APPLICANTS TO FILL IN QUESTIONS ON BOTH SIDES OF THIS FORM ONLY AFTER A JOB OFFER HAS BEEN MADE

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DATE JOB OFFER MADE
SOCIAL SECURITY NUMBER (Optional - See Privacy
Statement below)

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(Continue on reverse.)

PRIVACY NOTICE

Official Responsible: Medical Officer, State Personnel Board, P.O. Box 944201, Sacramento, CA 94244-2010; Authority: Government Code Section 18931; Purpose: The information you furnish will be used to evaluate your medical fitness to carry out the duties of the position applied for without endangering the health and safety of yourself or others; Providing Information: Medical clearance is required prior to employment in State service; Effects of Not Providing Information: Omission or misrepresentation may result in placement in a position where the duties or work environment could be hazardous; Access: Your medical records will be maintained in a confidential manner and may be reviewed by contacting the employing agency's personnel office.

HEALTH QUESTIONNAIRE

STD. 610 HQ (REV. 5-96) (Page 2 of 2)

ONSE satisfa to the Medic	T, YOUR actorily the hiring a	PRESENT CONDITION AS YOU EVA duties of the position for which you are gency unless (1) advised otherwise r, State Personnel Board, P.O. Box 94	of all items to which you have answered "YES" to LUATE IT and what accommodations to your line applying without endangering the health and safe by the hiring agency, or (2) for strong personal strong person	nitations, if any, you fee ety of yourself or others. onal reasons you pref	el you may require to perform Return this completed form fer to send it directly to the					
		ORS WHO WERE CONSULTED FOR CONDITION DESCRIBED ABOVE	DOCTORS	S' ADDRESSES						
complete	informa sentation (I certify that I have provided true and tion concerning my health. (Any or material omission may be cause for	APPLICANT'S SIGNATURE	DATE SIGNED	TELEPHONE NUMBER					
uisiriissai	/	AUTHORIZ	ZATION FOR RELEASE OF MEDICAL INFORMA	ATION						
TO:	-		er, hospital, clinic, or other medically-related facili f medical records pertaining to the person named							
			eligibility for employment with the State of Califo elow, any and all data and records concerning my							
		This authorization shall be valid for a to the State Personnel Board.	period of 90 days after the date of my signature	or earlier if revoked by	me in writing					
FROM:	STATE I	AL OFFICER PERSONNEL BOARD	I have a right to receive a copy of this authorization upon request.							
		X 944201 MENTO, CA 94244-2010	APPLICANT'S SIGNATURE		DATE SIGNED					
	APPLICA	NTDO NOT WRITE BELOW THIS LII	NEDELEGATED AUTHORITY OR STATE PER:	SONNEL BOARD MED	DICAL OFFICER ONLY					
REVIEWER APP	ROVED	QUESTIONAB	LESubject to Proper Placement (STPP)		DISAPPROVED					
IF DISAPPR	OVED, STAT	E JOB-RELATED RATIONALE; IF STPP, STATE RE	STRICTIONS							
REVIEWING	AUTHORIT	Y'S SIGNATURE		DATE SIGNED	TELEPHONE NUMBER					
REVIEWING	AUTHORIT	Y'S NAME (Typed or printed)								